(Cafeteria Plan) Family Status Change Form:

This form must be completed and attached to the EBD Health Insurance Change Form when submitting a request due to a family status change allowed under the Cafeteria Plan Rules. Valid family status changes include marriage, divorce, death, birth, loss of health coverage, adoption, etc. Please contact the HR Manager for further information.

PLEASE NOTE: Incomplete, illegible or otherwise unclear forms will be returned to you for correction and could possibly cause a delay in processing your request. Most family status changes must be requested within 30 days of the event date. Please notify the HR Manager immediately when any of these events occur.

Section 1: Employee Information

Please provide the requested demographic information.

- Department/Agency information is always Secretary of State, #063

Section 2: Indicate the Type of Change in Status Incurred

Select the type of change on the line provided.

Employee Signature:

- Provide the Date of Event on the line provided. This is the actual date you incurred the change. For example, if you get married, this would be the date of marriage.
- You must sign and date on the lines provided.
- Attach legal documentation to substantiate your change. Examples include: marriage, birth, or death certificates; divorce decree; notices of legal separation; proof of change in spouse's employment; or adoption papers.

Change Requested:

Do not complete this section. The HR Office will complete the information.

! Don't forget to return the form and any necessary attachments to the HR Manager to be processed. As a reminder, this form must be submitted with an EBD Health Insurance Change Form.

State of Arkansas Cafeteria Plan (ARCAP)
CHANGE IN STATUS FORM

Social Security #	Dept./Agency		
Last Name (Please Print)	First Name		MI
Home Address Street	City	State	Zip
Work Phone ( )	Home Phone ( )	E-mail	

Please indicate the type of Change in Status incurred:

_____ Marriage
_____ Divorce
_____ Death (employee, spouse, or dependent)
_____ Birth of child
_____ Adoption of child
_____ Beginning or end of employment of spouse
_____ Ineligibility of dependent (due to age, marriage or loss of full-time student status)
_____ From full-time to part-time employment or vice versa (employee or spouse)
_____ Unpaid leave of absence (employee or spouse)
_____ Significant change in health coverage due to spouse's employment

This is to certify that on _____ _____ (date of event), I incurred the Change In Status checked above, and therefore wish to change my plan benefits as indicated below. I understand that the change requested must be consistent with the change status event and I have attached legal document of such change.*

Signature _____ Date _____

*Examples of documentation include marriage, birth, or death certificate; divorce decrees; notices of legal separation; proof of change in spouse's employment; or adoption papers.

CHANGE REQUESTED

STATE EMPLOYEE INSURANCE PREMIUM CONVERSION

I wish to have the following premiums taken from my paycheck *BEFORE* taxes are applied.

☐ State Employee/Dependent Health Insurance and/or State Employee Life Insurance (Dependent Term Life Insurance is not included in Premium Conversion)

I wish to have the following premiums taken from my paycheck *AFTER* taxes are applied.

☐ State Employee/Dependent Health Insurance and/or State Employee Life Insurance (Dependent Term Life Insurance is not included in Premium Conversion)

If you are changing health and/or life insurance coverage, please indicate change below.

State Employee Health Insurance (check one)

☐ Change to Employee Only coverage
☐ Change to Employee & Spouse Coverage
☐ Change to Employee & Children coverage
☐ Change to Employee/Spouse/Children coverage
☐ Change to NO COVERAGE

State Employee Life Insurance

☐ Increase in Optional Life Insurance

Employee Cancer Insurance

☐ Change coverage to _____

Employee Disability Insurance

☐ Change coverage to _____

DEPENDENT CARE Spending Account

☐ **Terminate Account**

☐ **Start Account:** I wish to contribute $ _____ total during the remainder of this plan year, to be taken in equal installments from my remaining regular paychecks.

Change Existing Account:

☐ I wish to change from $ _____ _____ annual reduction to $ _____ _____annual reduction amount to be taken in equal installments from my remaining regular paychecks.

MEDICAL EXPENSE Spending Account

☐ **Terminate Account**

☐ **Start Account:** I wish to contribute $ _____ total during the remainder of this plan year, to be taken in equal installments from my remaining regular paychecks.

Change Existing Account:

☐ I wish to change from $ _____ _____ annual reduction to $ _____ _____annual reduction amount to be taken in equal installments from my remaining regular paychecks.

Cancer and/or Disability Premium Conversion (check one)

☐ I wish to have Cancer and/or Disability Premiums taken from my salary before taxes are applied.

☐ I wish to have Cancer and/or Disability Premiums taken from my salary after taxes are applied.

Please indicate any change in coverage: _____

Mail completed form to:
Fringe Benefits Management Company
Metropolitan National Bank Building
425 West Capitol, Suite 1518
Little Rock, AR 72201
Fax: (501)399-9333
Customer Service 1-800-342-8017

To be completed by **Fringe Benefits Management Company:**

Date received: _____ **Date confirmation sent:** _____
Date copy sent to state agency: _____
Payroll check effective date: _____
Number of remaining paychecks: _____
New Amount: _____
Authorized by: _____